Spirituality and Religion in Psychiatry: The Impact of Policy

Professor Christopher C.H. Cook
Department of Theology & Religion
Durham University

e-mail address: c.c.h.cook@durham.ac.uk

6 November 2017

Abstract

Research and debate on the importance of spirituality and religion in psychiatry has led to a number of national and international policy initiatives, intended to clarify the boundaries of good practice and improve the way in which such matters are managed for the benefit of patients. Significant amongst these is the 2015 Position Statement of the World Psychiatric Association, the only such policy statement to date which has been internationally agreed. Preliminary evidence available suggests that this is having good effect in generating professional debate and further national policy initiatives in different countries. There is a need for further research on such policy initiatives to confirm whether or not they have the intended impact upon clinical practice and whether or not this in turn is beneficial for patients.

Keywords

Spirituality, Religion, Psychiatry, Policy, Impact

Over the last 4 decades there has been increasing research attention to the part played by spirituality and religion in the assessment, understanding and treatment of mental disorders (Cook, 2012, Cook, 2015a). This, in turn, has generated discussion and debate concerning the associated ethical issues and the nature and boundaries of good practice (Cook, 2013a). Spirituality and religion (S/R) provide systems of belief and frameworks for living within which many people find meaning and purpose in life and resources to cope in time of adversity or illness. Research suggests that they are generally associated with better mental wellbeing, lower psychiatric morbidity and improved outcomes following treatment (Koenig et al., 2001, Koenig et al., 2012). However, they have the potential to impact on clinical practice in ways which may either improve mental wellbeing or else cause harm. In recognition of this, policies on S/R in psychiatry have been introduced with a view to clarifying and affirming the nature of good clinical practice and reducing harm due to poor practice. Amongst these, the World Psychiatric Association Position Statement on Spirituality and Religion in Psychiatry is particularly important as the only internationally agreed policy of its kind.

Concepts of Spirituality and Religion

Both spirituality and religion are conceptually controversial and difficult to define. In a definition later quoted in the position statement of the Royal College of Psychiatrists (see below), Spirituality has been defined as:

> a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately "inner" immanent and personal, within the self and others, and/or as relationship with that which is wholly "other", transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values. (Cook, 2004)

Religion is often contrasted with spirituality as being more concerned with institutions, hierarchies, dogma, tradition and ritual, but such distinctions are simplistic. In fact, spirituality and religion are closely related. Both have their subjective and experiential, as well as their social, institutional and historical expressions. Although more and more people in the western world identify as "spiritual but not religious", for most people worldwide spirituality and religion are inseparably related, and very few people identify as religious but not spiritual (Casey, 2013).

Because spirituality and religion are concerned with such fundamental matters as intimate relationships, and meaning and purpose in life, it is hardly surprising that they have become important in psychiatry. Psychiatry, directly and indirectly, is also concerned with these things. In various national psychiatric associations, such as the American Psychiatric Association (APA) and the Royal College of Psychiatrists (RCPsych) (Powell and Cook, 2006), and within the World Psychiatric Association (WPA), sections and interest groups have been established to give particular consideration to the relationship between spirituality and religion and psychiatry. These groups have been variously concerned with promoting debate, good clinical practice, continuing professional development, education and policy.

Guidelines and Policy

The APA was the first group worldwide to establish guidelines for good practice in relation to religion in psychiatric practice (Committee on Religion and Psychiatry, 1990). A more recent update of their guidance, approved in 2006, addresses both religious and spiritual commitments in psychiatric practice (Peteet et al., 2006).

Recognising the need for better guidance in the UK and internationally, in October 2005[1] the Spirituality and Psychiatry Special Interest Group at the RCPsych (SPSIG) began work on a draft position statement, making recommendations on spirituality and religion in psychiatry. This was submitted to the WPA Section on Religion, Spirituality and Psychiatry with a proposal that it might – after further discussion and redrafting – form the basis for a WPA policy document. In 2006 agreement was reached between SPSIG and the WPA Section that a WPA consensus statement, or position statement, addressing the need for guidance on spirituality and religion in psychiatry was a desirable objective.[2] Extensive efforts were made to gain international consensus, but this initially proved to be difficult to achieve (Verhagen and Cook, 2010) and so the SPSIG turned its attention to the national context. In 2011, after progressing through the formal procedures necessary to establish College policy, the document, by then expanded and revised as a result of debate and peer review within the College, was approved by the RCPsych as its position statement (Cook, 2011). It was subsequently further revised and republished in 2013 in the light of new guidance from the General Medical Council (Cook, 2013b).

In 2015, after prolonged international discussion and debate, a differently redrafted version of the document was agreed by the Executive Committee of the WPA as its position statement (Moreira-Almeida et al., 2016). Given their common origins in the same initial draft document, it is not surprising that these two position statements show a certain "family resemblance". However, the national and international processes led to different emphases. The RCPsych statement gained a much longer preamble, saying more about the concepts involved, the evidence base, and the national requirements of the General Medical Council. The recommendations of the two statements, despite some differences in wording, retained a lot of common ground around themes of good clinical practice, education and joint working with clergy/chaplains. Amongst those differences that may be identified are the reference to research in the WPA statement, lacking in the RCPsych statement, and the reference to local and organisational policy in the RCPsych statement, lacking in the WPA statement.

Following the publication of these statements, two further national policy/guideline papers have been published, the first in 2014 by the South African Society of Psychiatrists (SASOP) (Janse Van Rensburg, 2014), and the second in 2017 by Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde (DGPPN), the German national psychiatric association (Utsch et al., 2017). Written by different authors for different national contexts, these papers each follow a somewhat different approach, but they share common ground with the RCPsych and WPA position statements in respect of the key issues. Both acknowledge the influence of the earlier RCPsych and WPA position statements.

Whilst the WPA position statement was drafted with a view to broad international relevance and applicability, local cultural, religious and historical circumstances make it likely that differences of

[1] The first draft of this document was written by me. It was redrafted in the light of comments from other members of the SPSIG Executive Committee before submission to Peter Verhagen, who was then Chair of the WPA Section on Religion, Spirituality and Psychiatry.

[2] The story of work undertaken to achieve this objective is told more fully in an article by Peter Verhagen elsewhere in this special issue of *Mental Health, Religion & Culture*.

emphasis and content are required in different national contexts. Thus, in the early process of debating the draft WPA position statement, it was established that there were especial concerns as to applicability in eastern Europe and Japan, for political/historical and religious reasons respectively (Verhagen and Cook, 2010). In South Africa there is a concern with traditional healing practices (Janse Van Rensburg, 2014) and in the German speaking countries in Europe there is concern about the way in which spiritual interventions have been introduced into the practice of psychotherapy (Utsch et al., 2017).

Impact

The question arises as to whether or not such policy statements and guidelines have impact in practice and, if so, what impact(s) might be most desirable, what impact(s) actually have been (or might be) achieved, and whether or not these impacts are potentially measurable.

If indeed there is impact, the first place to look for this might most obviously be in those domains of clinical and professional practice in psychiatry to which the various documents explicity refer:

- Raising awareness & debate
- Better professional practice
- More/better joint working with chaplains/clergy
- Better training of psychiatrists on S/R
- More and better research on S/R
- Local policy initiatives
- Local service developments

A session at the 17th World Congress of Psychiatry in Berlin in 2017 was devoted to the WPA position statement, and a series of other sessions at the Congress were devoted to various aspects of spirituality/religion in psychiatry, suggesting that this is recognised as a topic of concern and interest to psychiatrists internationally. However, out of 10,000 delegates, relatively few attended these sessions. There is anecdotal reason to believe that the topic is also not always given close attention at other international conferences (Cook, 2015b). Thus, despite evidence that there has been vigorous professional debate (Cook, 2013a), the need to increase awareness of the issues and promote professional debate is ongoing. It is hard to imagine that such debate can be anything other than helpful to the profession.

There is little or no evidence at present to affirm that national or international policy has affected clinical practice for better or worse. Some local service developments have benefitted from the impetus that such policies provide (Cook et al., 2012) but it is impossible to know whether or not such intiatives would have taken place anyway – regardless of policy.

Presumably there might also have been other kinds of impact on practice – for example on policy and practice in other professions and in other areas of medicine. There are also those who fear that policies might have adverse impact (Poole, 2011). Evidencing these things in any systematic and quantitative fashion is time consuming, costly, and sometimes methodologically difficult.

National policy statements, and especially an international policy statement such as the WPA position statement, might also have the the potential to generate further national policy initiatives. These might include the development of new policies and guidelines, as has already occurred in South Africa and Germany, the revision of existing guidance, or a commitment to adhere to the WPA

recommendations. Informal personal communications with the author suggest that further evidence of impact of the RCPsych and WPA position statements in this way might continue to emerge in the years to come.

Ultimately, the impacts that matter are those achieved indirectly - on patient experience, mental wellbeing and treatment outcomes. Do policies on S/R and psychiatry actually improve the experience of mental health service users, reduce harm associated with poor practice, and enhance outcomes in terms of recovery and mental wellbeing? The research that could causally link introduction of policy to these dependent variables has yet to be undertaken and would be costly, methodologically challenging, and perhaps – in some cases – impossible. Despite this, it is to be hoped that research evidencing the impact of policies on S/R and psychiatry will be undertaken where possible. Even if it is not, the prima facie case for better policies on S/R and psychiatry is strong. It is hardly likely that psychiatrists will best serve their patients by not agreeing together on what good practice should look like. Nor has the lack of a direct evidence base prevented introduction of policies and guidance on the nature of good practice in medicine and psychiatry more widely, as for example (in the UK) by the General Medical Council (General Medical Council, 2013) and the RCPsych (Royal College of Psychiatrists, 2009).

Concluding Reflections

It is now twelve years since the process of drafting a WPA position statement on S/R in psychiatry was first begun, and it took eleven years from the point of first inception to publication in *World Psychiatry*. International debate evolves slowly at times, and consensus is not easy to reach. However, policy documents are not an end in themselves. It is only if they are read and acted upon that their benefit is realised. The impact of initiatives by RCPsych and WPA remain to be more fully researched, measured and monitored. The story of the benefits (or harms) for professional practice and the wellbeing of patients is only just beginning.

The author invites readers to be in contact by post or e-mail (c.c.h.cook@durham.ac.uk) with any information that they may have concerning local, national, or international impact of the WPA PS.

References

Casey, P. (2013) 'I'm Spiritual but Not Religious' – Implications for Research and Practice. In Cook, C. C. H. (Ed.) *Spirituality, Theology and Mental Health.* London, SCM. 20-39.

Committee on Religion and Psychiatry (1990) Guidelines Regarding Possible Conflict between Psychiatrists' Religious Commitments and Psychiatric Practice. *American Journal of Psychiatry,* 147**,** 542.

Cook, C. C. H. (2004) Addiction and Spirituality. *Addiction,* 99**,** 539-551.

Cook, C. C. H. (2011) Recommendations for Psychiatrists on Spirituality & Religion. *Position Statement.* London, Royal College of Psychiatrists.

Cook, C. C. H. (2012) Keynote 4: Spirituality and Health. *Journal for the Study of Spirituality,* 12**,** 150-162.

Cook, C. C. H. (2013a) Controversies on the Place of Spirituality and Religion in Psychiatric Practice. In Cook, C. C. H. (Ed.) *Spirituality, Theology and Mental Health.* London, SCM. 1-19.
Cook, C. C. H. (2013b) Recommendations for Psychiatrists on Spirituality and Religion. London, Royal College of Psychiatrists.
Cook, C. C. H. (2015a) Religion and Spirituality in Clinical Practice. *Advances in Psychiatric Treatment,* 21**,** 42-50.
Cook, C. C. H. (2015b) Spirituality, Religion and Psychiatry at the Annual Congress of the Royal College of Psychiatrists 2015: A Personal Reflection. *Spirituality & Psychiatry Special Interest Group Newsletter*.
Cook, C. C. H., Breckon, J., Jay, C., Renwick, L. & Walker, P. (2012) Pathway to Accommodate Patients' Spiritual Needs. *Nursing Management,* 19**,** 33-37.
General Medical Council (2013) *Good Medical Practice,* London, General Medical Council.
Janse Van Rensburg, A. B. R. (2014) South African Society of Psychiatrists Guidelines for the Integration of Spirituality in the Approach to Psychiatric Practice. *South African Journal of Psychiatry,* 20**,** 133.
Koenig, H. G., King, D. E. & Carson, V. B. (2012) *Handbook of Religion and Health,* New York, Oxford University Press.
Koenig, H. G., Mccullough, M. E. & Larson, D. B. (2001) *Handbook of Religion and Health,* New York, Oxford.
Moreira-Almeida, A., Sharma, A., Van Rensburg, B. J., Verhagen, P. J. & Cook, C. C. H. (2016) Wpa Position Statement on Spirituality and Religion in Psychiatry. *World Psychiatry,* 15**,** 87-88.
Peteet, J. R., Abou-Allaban, Y., Dell, M. L., Greenberg, W., Lomax, J., Torres, M. & Cowell, V. (2006) Resource Document on Religious/Spiritual Commitments and Psychiatric Practice. In Association, A. P. (Ed.). American Psychiatric Association.
Poole, R. (2011) Praying with Patients: Belief, Faith and Boundary Conditions. *British Journal of Psychiatry,* 199**,** 518.
Powell, A. & Cook, C. C. H. (2006) Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. *Reaching the Spirit: Social Perspectives Network Study Day, Paper 9.* London, Social Perspectives Network. 33.
Royal College of Psychiatrists (2009) *Good Psychiatric Practice,* London, Royal College of Psychiatrists.
Utsch, M., Anderssen-Reuster, U., Frick, E., Gross, W., Murken, S., Schouler-Ocak, M. & Stotz-Ingenlath, G. (2017) Empfehlungen Zum Umgang Mit Religiosität Und Spiritualität in Psychiatrie Und Psychotherapie. *Spiritual Care,* 6.
Verhagen, P. J. & Cook, C. C. H. (2010) Epilogue: Proposal for a World Psychiatric Association Consensus or Position Statement on Spirituality and Religion in Psychiatry. In Verhagen, P. J., Praag, H. M. V., López-Ibor, J. J., Cox, J. L. & Moussaoui, D. (Eds.) *Religion and Psychiatry: Beyond Boundaries.* Oxford, Wiley-Blackwell.